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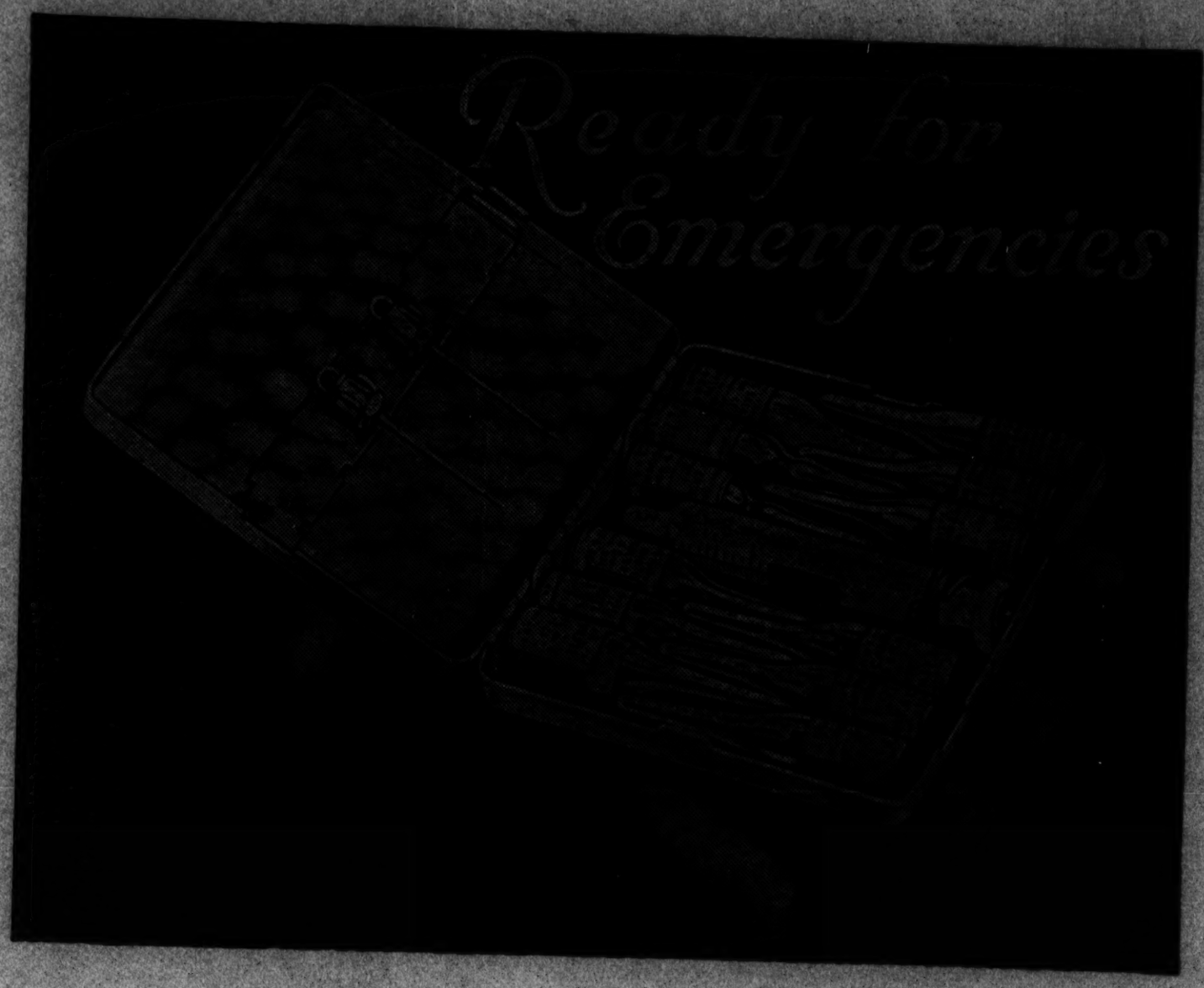

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The California Eclectic Medical Journal

Vol. ~~XL~~ XII MARCH, 1919 No. ~~X~~ 3

Original Contributions

A LITTLE MORE ON DRY DIET

Herbert T. Webster, M. D., Oakland, Cal.

Not so very long ago the writer relieved himself on this subject through articles contributed to Ellingwood's Therapeutist and the California Eclectic Medical Journal. These articles excited considerable interest, and a number of letters have reached me since concerning them. The majority of my correspondents report surprising success. One practitioner in Pittsburgh, Pa., apparently a more than average representative, remarked, in a letter received nearly a year ago, that "results in half a dozen or more cases were little less than miraculous." Two of my correspondents have manifested themselves as a little sore because they undertook its application. They manifestly had lost friends and prestige through it. At this I am not surprised. One who attempts to practice it is up against a wall of prejudice as well as a craving for drink on the patient's part which will sap the courage of one who does not possess a mountain of faith in the efficacy of the method of cure.

The practitioner who attempts this form of practice will face a rocky road, whether it lead to success or not; and there are often certainties of failure, because some conditions of the body in disease interfere with the carying out of its provisions. However, the treatment will perform wonders when the only outlook under ordinary conditions is certain death. No patient who does not realize this and who does not possess a philosophical disposition and an abiding faith in his physician, believing his judgment is better than that of all the world besides, should enter on the treatment; for once begun and abandoned, the treatment receives a black eye, from which recovery is difficult.

I predict that it will be a thousand years before dry diet will become a popular form of practice. It requires magnificent self-sacrifice and self-denial on the part of the subject. Christian Science is much more attractive, and requires little self-denial; though, as in the case of the little daughter of an old patron who has become a Scientist, who (daughter) denied very positively, when brought to me with a case of old-fashioned itch (scabies), that there was any itching, they (Scientists) may sometimes be compelled to lie, if they live up to their doctrine.

I am going to give a desultory description of two cases which have interested me, and which have occurred since my last articles were written; it seems as though something might be learned from them. Both were female patients, and both somewhere in their sixties.

The first one had been a patient in time gone, but circumstances of residence had separated us for ten years or more. She had had reverses until she was compelled to struggle for a livelihood, and had devoted herself during that time to a small poultry business, that of raising chickens and selling eggs. A fungus growth appeared at the orifice of the left nostril and began to ooze a watery, bloody discharge. She resorted to a somewhat famous sanitarium in the Napa valley, where a corps of physicians and surgeons undertook to treat all kinds of medical and surgical diseases successfully . She spent several months there, and then visited the place for treatment at regular intervals. After a year, the leading surgeon said that nothing could be done for her. She "had applied too late." At this point she looked me up, for a little comfort, and that was all she expected, for she had been informed that her case was one of cancer.

The left nostril was distended with an angry fungus growth, as large as a small walnut, from which a sanious discharge slowly oozed. Excrutiating pains radiated from the tumor far up into the nostril, into the left eye and into the forehead. She had lost much flesh, and her color was suggestive of cancerous cachexia. She was weak, sleep was broken, and anorexia was pronounced. Naturally, she was ready to give up the battle.

I was about leaving for an extended trip into the mountains, and could not give such a case the attention it demanded, but informed her that probably only one treatment in the world would do her any good, but thought it possible this might cure her if properly applied; but that she must give up work,

go to bed, and have constant attendance, and prepare for a large amount of self-denial if she hoped for any benefit.

I then explained the dry diet idea and described it fully, but told her she could hardly expect to go through such a treatment without professional aid and advice. I saw her again about a month later, and found she had been following directions faithfully, but had been obliged to abandon her chicken ranch and hire a room to hibernate in. She was still without an attendant or nurse. I doubted her ability to make a success of the treatment, but gave her the best advice occurring to me under the circumstances. I left town a few days after this, and did not see her again for probably eighteen months. In the fall, after returning to town, I learned, through someone who knew her that she remained on the diet for six weeks, when she became so weak that some officious friend or well-wisher concluded she was at the point of death and conveyed her to a hospital to breathe her last. I supposed of course she has passed away, but one day while walking on Broadway some one in the passing throng called me by name. I turned, and recognized a neighbor who had accompanied her on her last call at my office.

She hurried up and said, "Have you seen Lottie lately?" "From what I heard some time ago, I supposed Lottie was dead," I replied. "Oh no; she is as well as ever." I learned that when she seemed about to die, and went to the hospital for that purpose, she began to take her meals regularly, the cancer disappeared, and she went home in a few weeks and resumed chicken ranching.

Something less than a year later I met Lottie on the street, looking as rugged as I had ever seen her. The bridge of her nose was flattened as though it had come in contact with a pair of brass knuckles, but her color and flesh, and the snap in her eyes, all betokened pretty good health, and she said she felt as well as she looked. She told me she had taken no medicine nor had any application made to her nose from the time I saw her to that time, so she gave the dry diet credit of curing.

Ordinarily I would have expected three to six months of treatment if not more, to have brought about such a result. It was certainly good luck and not management that brought her through, for I am as certain that her trouble was cancer as I have ever been certain of anything in diagnosis. It is astonishing that six weeks could have wrought such a cure; but while she was at it, she informed me, she pushed the treatment for all it was worth. Doubtless she overdid it, for

she needed a mentor, and did not have one. However, all's well that ends well. I have recently been treating this person for a severe attack of flu, and she has recovered well. She promises to live to be eighty at least, for she comes from long-lived stock.

A more recent occurrence was my experience with another case which did not turn out so favorably. This woman was sister to an elderly lady whose confidence I had won several years before by making a good carpenter of her husband, after he had become a bedridden invalid. This was largely luck, but it made me a good friend, which I am afraid I have now lost, through dry diet. This woman's sister, a widow of a little past sixty, had come from the upper San Joaquin valley to Oakland to remain with her sister while securing medical aid for a growing decline. A prominent Oakland physician undertook the investigation of her case, but after exhausting his best resources instigated a blood examination, and received the diagnosis as pernicious anemia, from the laboratory. He immediately reported a hopeless prognosis, and abandoned the case.

I could offer nothing but dry diet as a possible means of cure, and the patient was eager to have it tried. She entered upon it with enthusiasm, and persevered with spartan pluck for about five weeks. I noted the urine upon each visit, and toward the end observed gluey masses, occasionally, at the bottom of the glass, as large, at times, as a small bean. These were something new to me, but I ascribed them to the breaking down of diseased blood corpuscles. The first thing this treatment does is to break down diseased tissues. But could the kidneys eliminate large quantities of such material from the circulation ? By this time the lemon color had disappeared, the skin was natural in appearance, appetite was improved, and the patient began to get up and around, where before she had been too weak to even sit up in bed. She also slept well nights, while before, insomnia was a troublesome feature. Prospects now seemed encouraging; but I was called one morning urgently, and found the patient suffering excrutiatingly from pain in the right foot. Nothing relieved. Internal agents and local applications failed; even morphia, hypodermically, could not relieve. In a few days the great toe began to darken, and I was confirmed in the fear that an embolism had formed, and was blocking off the circulation to the part. A few days more and the whole foot was black.

I informed the friends that the only hope was amputation, but they were horrified with the idea, and proposed calling

the former attendent. I assented to this, but when he insisted upon the same procedure, they concluded to abandon doctors and let the patient die without any further effort. I did not hear from her for several months; four, at least. One day not long ago I met the brother on the street, and he informed me that his sister was at her home, near Visalia, still alive. It is possible that she may yet recover, if she finally consents to amputation.

There is a lesson in this case. Destruction of large numbers of diseased blood corpuscles within the circulation presents a formidable obstacle. Whether dry diet is justifiable in such cases is a serious question. The case has justified all the claims made for dry diet, but such instances as this leave the practitioner small prospects of credit.

PNEUMONIA-ETIOLOGY AND TREATMENT

M. S. Aisbitt, M. D., Los Angeles

(Read before the Los Angeles Eclectic Medical Society)

Pneumonia is inflammation of the lungs superinduced by an influx of blood into the parenchyma of the organ or organs as the case may be. The disease may be located in one lung or in both lungs, producing slight pain, unless the pleura is involved which would increase the pain by the lungs pressing the inflamed pleura against the wall of the chest. This would come under the term Pleuro-Pneumonia and if the bronchi were implicated it would be Broncho-Pleuro-Pneumonia. This condition would increase the pain over both sides of the chest and the condition would be grave should this complication take place. In addition there would be an increase in the pluse and temperature and a dry hacking cough with rusty, frothy sputum often tinged with blood. This frothy sputum is very characteristic of inflammation of the lungs. Percussion and auscultation will reveal an accurate condition of the heart and the extent of the disease.

Etiology. I am almost afraid to enter into a discussion of pneumonia as there are so many theories advanced pertaining to its cause, nevertheless we have to keep on until we accidentally find a scientific cause for it.

The animal body has never been studied as a chemical structure and until that time comes we will have to struggle along theoretical paths expecting to capture the offender. The prevailing theory, at the present time, is the microbe. I have never been converted to this idea; it is simply a com-

she needed a mentor, and did not have one. However, all's well that ends well. I have recently been treating this person for a severe attack of flu, and she has recovered well. She promises to live to be eighty at least, for she comes from long-lived stock.

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mercial business. Instituted by chemical speculators (a German propaganda) claiming, as they do,. preparing drugs from diseased matter will prevent and cure and immunize people from taking special forms of disease. In order to find a scientific principle involved in the cause of pneumonia I will have to take you over the blood steam beginning with the heart. The right side of the heart receives the venous blood from the ascending and descending veins, carries it into the right auricle from there into the right ventricle, from the right ventricle through the pulmonary artery to feed the tissues of the body. Now herein lies the secret of a great many diseases, especially epidemics. Now suppose the blood does not receive enough oxygen in order to oxidize the different elements in the blood, the tissues would fail to be nourished, hence you would expect to have some impairments of health (disease). The blood thus oxidized is returned through the pulmonary veins to the left auricle then into the left ventricle and through the aorta to the remote parts of the body. Now we have three sections of vessels, arteries, veins and capillaries. The temperature of the body in a state of health should be about 98F. Should this temperature be reduced below the normal by a chill or chills which will interrupt the circulation of the blood, it would cause a contraction of the capillaries and reduce the lumen so that it would impede the blood from returning from the arteries to the veins. This empediment would be the primary cause for congestion of the lungs while at the same time the heart is forcing the blood into the lung tissue. When this condition takes place it is transmitted through the medium of the cortical part of the pneumogastric nerve to their nerve centers. These nerve centers secrete an extra amount of material in order to augment the nerve forces which increases the heart's action and elevates the temperature of the body. The spinal accessory nerve reenforces the pneumogastrics and the phrenic nerve in the diaphragm.

Treatment. In treating a case of pneumonia with the above conditions involved we have to select such agents that will counteract and move them back to normal. The first would be to reduce the heart's action, and second to reduce the temperature. I would select aconite. This drug acts specifically on the nerve centers of the pneumogastric nerve. It is an anaesthetic as well as being a sedative. It will reduce the temperature and bring the heart's action to normal. To aid these two propositions I would add belladonna. This drug acts upon the capillaries relaxing their contractions and enlarging the lumen creating a free passage of blood from the congested lung or lungs. In addition to the aconite and bella-

donna add hyoscyamus which will relieve the irritation of the bronchial tubes. If there is much pain in the chest give bryonia and lobelia. Apply warm applications to the lower parts of the body and to the chest. Give plenty of hot drinks in order to get the patient into perspiration. Reduce the heart's action as quick as possible in order to prevent developing into tuberculosis. This treatment for pneumonia in its acute stage has served me sufficiently without a single death. Then why would we break away from it and take up some other method which would be a speculation and an experiment to the patient. To practice the healing art it should be a fact and not a theory.

EXPERIENCES WITH THE "FLU"

Dr. H. Ford Scudder, Los Angeles, Cal.

(Read before the Los Angeles Eclectic Medical Society)

In a conversation with Dr. O. C. Welbourn the first part of October, he mentioned the fact that Dr. Gibson had reported wonderful success in the treatment of cases of influenza with large doses of Lloyd's Gelsemium "Red," using one to two teaspoonfuls to four ounces of water. As I had had no cases up to that time, I resolved to remember it.

A few days later I had my first case. Boy aged 16, temp. 103 3-5 at 2 P. M. Usual symptoms, sudden onset of disease, severe frontal headache, dry hacking cough, pain across lower part of back, etc. The case presented a typical Gelsemium picture, "flushed face, bright eyes, contracted lips, increased heat of head, and general headache." I prescribed Veratrum, gtts. 20, Bryonia gtts. 10, water ounces 4, and added one full teaspoonful of Lloyd's Gelsemium "Red." One teaspoonful of the mixture to be given every hour while the patient was awake. Then directed that one teaspoonful of Epsom Salts or same quantity of Abbott's Saline Laxative be given every four hours until bowels moved four times daily, and that the diet be restricted to hot liquids, all the cold water the patient wanted to drink and a little orange juice occasionally. The next afternoon the temperature had dropped to 100 2-5 and patient feeling decidedly improved. Same prescription repeated except that the Veratrum was reduced to gtts. 10. Next afternoon the temperature was normal 98 3-5 and the patient begging for something to eat. The usual directions were given as to the diet, the necessary rest in bed, time of patient's getting up, etc., and I was out of a job on the third day, due I should say, to Gelsemium "Red."

Now regarding Gelsemium, will say that I have used it off and on for years, always getting perfect results when indicated, but have been very conservative as regards the size of the dose, usually restricting myself to the use of 20 to 30 drops in 4 ounces of water, except in spasmodic troubles when I give 5 drop doses. That was the usual dosage employed about 8 months ago. At that time I had a case of a man aged 40 who had had two previous attacks of cramping of the muscles; the first the muscles of the upper arm, the second of the muscles of the back of the neck. They would knot up in a hard lump. The third attack seemed much worse, patient very nervous, afraid he would be paralyzed, seemingly making terrible struggles to get his breath, pounding his chest, clutching his throat, etc. As I was suspicious of hysteria and didn't care to be the one to suggest the same I called my friend Dr. Roath. I had started out giving 5 drop doses of Gelsemium every 10 minutes followed by a hypo of one-fourth grain morphine with no effect. Dr. Roath suggested it was too bad I hadn't given him apomorphine at first instead of morphine, but that we would give him some Gelsemium hypodermically. After I had seen him load his hypo syringe full of Gelsemium and inject the entire amount I came to the conclusion that it was really "some" Gelsemium for one dose. I learned from the patient the next day that about an hour after the last hypodermic he had relaxed thoroughly and had no more trouble. Needless to say that after informing the wife as to the hysterial side of the equation, there has been no return of her husband's trouble. While this case has nothing to do with the "Flu," I give it as relating to the use of Gelsemium. Also from this case my fear of using large doses of Gelsemium has vanished.

Fyfe in his Materia Medica gives the dose of Specific Gelsemium as 1/10 to 10 drops. Ellingwood in his Therapeutics from 10 drops to 2 drams to water ounces 4, teaspoonful every half hour to two hours, and states as follows: "Gelsemium is a prompt remedy if given in sufficiently active dosage. The excellent results obtained by the older physicians were obtained from full doses. If toxic effects are obtained they are readily observed and antagonized with no harm to the patient. Gelsemium is quickly eliminated from the system, largely through the kidneys, consequently the effects of single doses are quickly dissipated, and the doses must be given frequently to secure good results." In my experience in the recent epidemic I have depended largely on Gelsmium "Red," using either one or one and a half teaspoonfuls to half glass of water, and getting evcellent results. An ordinary teaspoonful

or a full teaspoon will hold from 70 to 90 drops, making the dosage two or three drops. It allays the nervous irritation, and the throbbing headache, relieves the tension, and lowers the temperature. Other remedies used were, veratrum and aconite as sedatives, getting good results especially from Veratrum. Asclepias, in catarrhal affections, pleurisy, and especially as a sedative with children—Bryonia, for pleuritic pains —Rhus Tox fof frontal headache—Lobelia, Ipecac, Veratrum in Broncho-Pneumonia. In all cases showing the least sign of pulmonary complications, I used the cotton jacket; also used Libradol as long as I was able to obtain any. The remedies named above were all specific medicines, not any Aconitine in granules, nor Gelsemium in tablets or tablet combinations. I used the salines as part of the routine treatment, a teaspoonful of Epsom Salts or preferably Abbot's Saline Laxative every thre or four hours until the bowels moved three or four times daily as long as there was any temperature, and the diet was restricted to hot liquids. I have had quite a few cases with marked indications for Baptisia; have used some Macrotys, but not a great amount. I never used Eupatorium Perfoliatum as there was none of the new Colloidal Specific Medicine to be had. I have used Euratorium previously for deep seated pains and aches with splendid results but the medicine made such a nasty mixture that I had about discarded it. The new Colloidal form of Eupatorium though is an elegant preparation and makes a fine mixture. I have been accustomed to use about one dram to four ounces of water, but I notice by the latest literature on the subject that the Collodial form is recommended to be used in much larger doses, half to one ounce to four ounces of water. In its new Colloidal form Eupatorium Perfoliatum is a remedy that demands careful study. While I didn't use any Aspirin during the epidemic, I did use quite a few Migrane Tablets No. 5, Parke Davis & Co., containing Acetanalide 2 grs., Camphor Monobromated half gr., Caffeine one-quarter gr.

In the beginning of the epidemic when my friend Dr. Roath was under the weather for several weeks, I had lots of experience in the Italian colony north of the river. It was there that I saw the real thing. I had as high as nine cases out of a family of ten. Every family averaged three or four cases. As fast as you finished at one place there would be someone waiting at the machine to take you across the street to three or four more cases, etc. They couldn't get nurses if they had had money. Always managed some way to keep one member of the household well long enough to wait on the others. It was a question of salts and soup, glass medicine, orange juice,

and cold water. I remember distinctly in one family with six sick, a little girl named "Rosie," aged 10, did all the nursing, and proved to be a very fine one. Kept the kettle of soup going, passed out the salts, and gave the medicines according to directions. Saw several different kinds of treatment in follow-up cases, where the first doctor had either been taken sick or discharged. One "Medical Osteopath" who was using Lloyd's Libradol as an application to the chest. There was the oiled paper, green color, and familiar odor. Still he told the wife that it was a special preparation called "Indian Mud." He retired to the kitchen, carefully closing the door and prepared the same from his bag of medicines. Another "Medical Osteopath" who had his medical directions written out along with his diet list. His "very successful" medication consisted of three teaspoonfuls of Sweet Spirits of Nitre in half glass of water, teaspoonful hourly for the fever, and about half dozen little white pills given at intervals of two hours to make the patient sweat. Very likely Pilocarpine. However, I consider he was far ahead of a certain Allopath whom I followed up in three cases. This man took no chances, he brought his own Aspirin with him, leaving a box of twelve five-grain tablets with directions that two tablets be given every two hours. He also ridiculed the idea of soup, saying no one could obtain any strength from soup, but "feed him up, feed him up." Another's treatment consisted of deep muscular injection of Quinine every day, and directions to "tempt his appetite." Another case I ran onto about 2:30 one night. Man about 40 years, weight 220, temperature 101. Found the patient as well as the wife scared to death. Doctor had told him that he had pneumonia of the root of both lungs; had his entire chest covered with a green shade hung exactly seven inches from the poultice. The doctor saying that this was the only way to keep an even heat to the lungs. Sleep was out of the question; he did not dare move or he would be out of the seven-inch measurement, and there was that bright light constantly shining in his eyes. To be on the safe side I put on a pneumonia cotton jacket. His lips were thick, his face had a congested appearance, mind dull, and a bluish look to the tongue and mucous membranes. Belladonna and Baptisia together with a little encouragement, getting rid of his load of flaxseed and the green shaded light, etc., soon accomplished a complete change for the better.

I have outlined my treatment in general, not because I think it is anything wonderful, but because I think I have had good results. Of 285 cases I have lost four. I consider that

I merely signed the four death certificates for the other doctors who passed them on to me at the seventh or eighth day when they were too far gone to respond to any sort of treatment. In closing would say that the essentials of treatment of Influenza are:

1. Rest in bed.
2. Hot liquid diet.
3. Plenty of cold water to drink. Acid drinks.
4. An open free bowel, whether from salines, laxatives, oil or enemas.
5. Gelsemium "Red" and Specific Medication all the time.

AN EXPENSE ACCOUNT

Germany is helping pay the expenses of the American Army of Occupation. Already a total of more than three million dollars has been delivered by special trains to General Joe Dickman at Coblenz and other expense accounts will be rendered.

This money and the other millions that Germany will pay do not comprise a loan. They are dead losses. They will bear no interest and will never be returned.

Germany lost the war. If she had won special trains would be running from Seattle, San Diego, Portland, Salt Lake City, Oakland, Los Angeles, Spokane, San Francisco, Phoenix, Reno and scores of other western cities hurrying money and supplies toward big German liners waiting to put out from New York harbor for Hunland.

Your money would go. It would not be a loan. You would receive no interest and you would have no idea of the particular purchases made with your savings. You would "dig" when the Germans said "dig."

And who protected you from this situation? Who determined that Germany and not you should give up saving? Who met the German "schrecklikeit" on land and water and drove home our victory?

Can you say honestly that the war is over when they are not even home, their wounds cured, their compensation paid and the bills contracted for their victory fully met?

When the Victory Loan comes along in April don't sit back and say you've done your part. Compare whatever you have done with the sacrifices made by our sailors and soldiers. If they had quit when they had been in one or two stiff fights you'd be loading up those special trains for Germany and paying the expenses of a German Army of Occupation.

THE CALIFORNIA ECLECTIC MEDICAL JOURNAL

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Contributions, Exchanges, Books for Review and all other communications should be addressed to THE CALIFORNIA ECLECTIC MEDICAL JOURNAL, 819 Security Building, Los Angeles, California. Original articles of interest to the profession are solicited. All rejected manuscripts will be returned to writers. No anonymous letters or discourteous communications will be printed. The editor is not responsible for the views of contributors.

YOUR PATIENT'S CREDIT

The relationship between a doctor and his patient is a mutual one. The doctor is obligated to use his best skill and the patient is obligated to make a proper remuneration therefor. Should the doctor fail in his obligation he is guilty of mal-practice. Should the patient fail in his obligation the doctor has added another deadbeat to his list—he can do nothing. In the opinion of the writer he has actually done his patient harm because he has confirmed him in his vicious habits. He does not even receive the patient's gratitude, for such men do not appreciate a service that costs them nothing. Furthermore, that this doctor is an "easy mark" is passed on to others of like ilk, and his reputation as such is established. Some of our colleagues have allowed themselves to be put in this class, much to their sorrow, because it means constant financial distress.

In the country a patient has a reputation and the degree of his credit can be easily determined, but in the city it is quite different. However, in these days of war thrift every

man worth considering has bought one or more Liberty Bonds, and he, being a stranger and honest, should deposit these with the doctor as security and thus establish his credit. Should he have previously disposed of his bonds, his credit is poor. He may be honest, but he lacks thrift, otherwise he would have saved his bonds for such an emergency. He belongs in the C. O. D. class. Some doctors, having a paternal heart, are trying to teach their patients to save for that rainy day. It is a worthy cause and to such we commend the War Savings Stamp.

DEATH OF RICHARD E. KUNZE, M. D.

Dr. Richard E. Kunze, aged eighty-three years, died at his home near Phoenix, Ariz., February 7, 1919.

The writer visited him only ten days before he died, and found him very much emaciated and feeble, having failed rapidly in health during the past year. He was practically helpless and had to be lifted back and forth from the chair to his bed. His mind was also somewhat clouded, and he did not recognize his friends when they called to see him; but when he spoke, his high pitched shrill voice sounded as strong as ever.

He lived very plainly and simply and spent much of his time alone during recent years. In his later years he was troubled with an eczematous eruption over his body which annoyed him greatly, and persisted up to the time of his death.

He had not practiced medicine for many years and spent his time on a little farm, growing cactus, which he sent abroad and sold in foreign lands. Nearly all of the cactus growing in European gardens was furnished by him, which occupation supplied him with a modest living. When the overseas war broke out, ocean traffic and the cactus business ceased and seriously curtailed his income. His was no easy life, but a constant struggle with hard work and hardships, that would have discouraged most men; yet he was never disheartened. He was well educated and spoke and wrote several languages. He was interested in natural science and was an esteemed member of several scientific bodies.

He began his professional career in New York City, and is remembered by the older Eclectics as an original investigator of drugs, the discoverer of cactus as a heart remedy, and as a forceful writer.

His health failing, he left New York for Colorado, but after only a short sojourn, went to Phoenix, Ariz., to live among

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his beloved cacti. He was very fond of the desert, and spent much time exploring its secrets. In his youth he became an expert horticulturist and never tired of investigating nature. He was credited with making new discoveries in botany and entomology and was a frequent contributor to scientific journals.

Dr. Alexander Wilder, an almost lifelong friend and admirer, wrote his life which appeared in the June number of the American Medical Journal of St. Louis, in 1908.

J. A. MUNK.

LIBERTY LOAN SHARKS

A warning against Liberty Loan sharks and a request for information concerning the operations of Liberty Loan swindlers is contained in a statement just issued by Carter Glass, secretary of the treasury.

Following is the statement:

"My attention has been directed to the activities of unscrupulous persons who have been operating extensively throughout the country and who are swindling the owners of Liberty Bonds by purchasing bonds at prices far below their actual worth.

"These swindlers get the attention of Liberty Bond owners by publishing advertisements calculated to make the unsuspecting bond owner believe that the highest market price can be secured for his bonds through the agency of the advertiser. Such is rarely, if ever, the case. Records of transactions of this character, brought to the attention of the Department of Justice and the Treasury Department, prove conclusively that these swindlers take every advantage of bond owners who are forced into their own clutches by paying the lowest possible price which the owner will accept—and generally far below the actual value of the bonds.

"I regret to observe that many reputable newspapers are being victimized by accepting the advertisements of these swindlers, and I appeal to all newspaper publishers to scrutinize very carefully the character of individuals who use their columns to offer to buy Liberty Bonds. As a newspaper publisher, I believe that it is the duty of publishers to protect their readers against unscrupulous advertisers.

"Other swindlers endeavor to trade worthless articles or securities of little value for Liberty Bonds, and I appeal to patriotic publishers to assist in putting an ends to this practice.

"The Treasury Department will take such steps as are possible under the law to protect the interests of holders of Liberty Bonds, and will use every means at its command to bring to justice all who seek to defraud the people who have so patriotically assisted in winning the war by investing their savings in Liberty Bonds and War Savings Stamps.

"Owners of Liberty Bonds and War Savings Stamps should in no circumstances part with these securities unless necessity compels, and then they should deal only with reliable banks, trust companies, banking institutions and others whose reputation for integrity is beyond question. If it is necessary to sell Liberty Bonds the highest market value should be received.

"The Treasury Department will welcome information concerning the operations of these swindlers in any part of the country."

CARTER GLASS,
Secretary of the Treasury.

SOME CLINICAL EXPERIENCE WITH INDICANURIA

Clifford Mitchell, M. D.

What is indicanuria? What does it signify, and how should we treat it? These questions are of some importance to those of us who deal with obscure chronic conditions, and it is the object of this paper to contribute a mite of information obtained by the writer after experience of many years in urine testing.

Chemically speaking, there is no such thing as indican in the urine, since indican is a product of vegetable origin, a glucoside, which is not found in urine at all. But the term indicanuria has been adopted by clinicians to describe a condition in which we find a marked blue color produced in certain urines by addition of certain chemicals. Normal urine, as is well known, contains certain aromatic substances in small quantities, among which are the so-called ethereal sulphates (conjugate sulphates), combinations of sulphuric acid with oxidation products of indol and skatol, and also with paracresol. phenol, etc. Indol, C_8H_7N, formed in the large intestine as the result of the putrefaction of proteins, is absorbed, becomes oxidized in the blood to indoxyl, C_8H_7NO, and appears in the urine as a conjugated sulpho-acid salt of potassium, $C_8H_7NO.KSO_3$.

In the tests for "indican" the indoxyl sulphate is further oxidized by the chemicals used into indigo-blue, hence the

blue color obtained. Now, in my hands this same reaction has been found to be elusive and unsatisfactory in that it has at times been faint or absent in cases where intestinal indigestion was plainly present. Just why this difficulty has been encountered has been the object of considerable investigation, and I have finally arrived at the following conclusions: In the first place, there are probably different stages in the oxidation of indoxyl to indigo blue, and under certain circumstances of oxidation the blue may not be obtained at all, but replaced by certain tints of red. We insist, however, upon the production of a blue color in our clinical tests, and this paper deals wholly with the ways and means necessary for obtaining the blue. Again we use hydrochloric acid in all the indican tests. This acid, as it now occurs in the concentrated form in commerce, is a solution of hydrochloric acid gas in water, having a specific gravity of 1.19. Now, in the year 1882 the acid of the German pharmacopœa had a specific gravity of only 1.16. In other words, the concentrated acid we now use contains much more gas in solution than the pharmacopœa acid of Germany in the days of Jaffe and others. Further, in connection with the test it is customary to use, in addition to the hydrochloric acid, some oxidizing substance, as, for example, one setting chlorine free. But it has been remarked by observers, as e. g. by Ogden, that this oxidizing substance is not always needed when the hydrochloric acid contains an excess of gas, as the modern concentrated acid frequently does. True it is that the oxidizing substance is frequently not needed, but in my experience it is apparently due more to the proportions used than to excess of gas in the acid.

However, to be concrete, let me narrate my experience as follows: Years ago I began to test for indican in urine, using the Jaffe test as modified by Stokvis. This test is performed as follows: To ten cubic centimeters of urine are added ten of hydrochloric acid and a drop or two of a solution made by dissolving in water the ordinary household disinfectant, "chloride of lime" so-called. The mixture is immediately shaken or stirred and the presence of indican demonstrated by the production of a blue color. On further adding two cubic centimeters of chloroform and shaking vigorously the indigo blue is extracted by the chloroform, the latter settling to the bottom of the glass and the relative amount of indican can be guessed at by the hue of the chloroform. I used this test for many years, contentedly enough and without questioning its reliability. One day, however, a patient came into

the office, plainly suffering from intestinal indigestion, and on testing his urine for indican I was disappointed in not obtaining a marked reaction. This set me to thinking, and I decided to repeat the test on the same urine, but to vary the proportion of urine and acid. So, first, I tried five parts urine to ten acid, and to my surprise immediately obtained a marked blue color. Being then convinced of the superiority of my new proportions I discarded the proportions of Jaffe and adhered to my own figures for many years. By the use of these new proportions I obtained many brilliant indican reactions and saw no reason for going back to the original method of Joffe until this winter (1909), when the following "unexpected" happened: In testing the urine of a diabetic who was an enormous meat eater, I found with my own acid used with my own proportions a brilliant indican reaction. But when I took this same urine to Hahnemann college for demonstration, and used the college acid the experiment failed, and not one of the students could obtain the reaction. We then changed the proportions of the urine and acid to ten each and the reaction was at once obtained with intensity. Taking the sample back to my office and testing it with my own acid no reaction was obtained with the proportions of ten urine and ten acid. But with five urine and ten acid the reaction at once occurred as before. In other words, using the same urine with different samples of hydrochloric acid the reaction was obtainable in the one case only with five urine and ten acid, and in the other only with ten urine and ten acid. I next tested 50 different samples of urine with hydrochloric acid in my office, using with all the proportions of five urine to ten acid. A surprising number of negative results were obtained, only eight being positive, and of these only five intense. But on selecting 13 of the negative urines and testing them over again in the proportion of ten urine to ten acid brilliant reactions were obtained in seven.

Furthermore, in the case of a sample of urine, sent to my office by a physician who said that he had found indican, testing in the proportion of five urine to ten acid no reaction could be obtained, but on trying it with ten urine and ten acid on intense color was produced. I then tried all the tests for indican I could find in the books on this particular sample of urine, and found those requiring the use of nitric acid more or less unsatisfactory so far as this sample was concerned. The tests which gave the most marked blue color were the Jaffe, Stokvis, and the test of Obermayer. Continuing to

experiment with other samples I finally found it desirable to use four tests on each sample. These four are, first, the Jaffe test with the original proportions; second, with my own variation of these proportions; third, Porter's test, and fourth, Obermayer's test. Porter's test for indican is as follows: To ten c. c. of urine add a like volume of concentrated hydrochloric acid, then three drops of a one-half of one per cent. solution of potassium permanganate, then a few drops of chloroform, then a drop or two more of permanganate, and finally chloroform again, in all enough to make five c. c., and shake the whole vigorously for a few seconds. Obermayer's test is as follows. The urine is precipitated with a twenty per cent solution of acetate of lead, in proportion two c. c. of the lead solution to ten of urine. The mixture is filtered, and to the clear, filtrate is added an equal volume of Obermayer's liquid, viz.: a solution containing two grammes of ferric chloride to a liter of concentrated hydrochloric acid. Two cubic centimeters of chloroform are added and the mixture slowly shaken. A clear rich blue is obtained when indican is in excess.

The following ten cases will serve to illustrate the value of using more than one test for indican. In describing what happens I use the term negative in cases where no color is noticed in the chloroform on settling until some minutes have elapsed, positive when the chloroform is almost immediately colored a marked blue.

Case 1. Normal urine of a man two hours after a hearty lunch on a mixed diet including red meat: all tests negative; a faint color with Obermayer only.

Case 2. Medical student who has not eaten meat in two days: all tests negative or faint.

Case 3. Twenty-four hours' urine of a man suffering from indigestion: all four tests strongly positive, except in the Mitchell-Jaffe proportion.

Case 4. Twenty-four hours' urine of a man on a diabetic diet, who for years has had irregular bowel action: only one test marked, namely the Stokvis-Jaffe.

Case 5. Twenty-four hours' urine of a man complaining of great debility, dizziness, and depression of spirits: urine negative as regards albumin, sugar, and casts; all four tests for indican strongly positive; Obermayer's least marked.

Case 6. Twenty-four hours' urine of a man with presumably chronic interstitial nephritis: no marked reactions, but the Stokvis-Jaffe test is moderately plain, as also the Obermayer.

Case 7. Twenty-four hours' urine in a long standing diabetic case with five per cent. of sugar in the urine: brilliant reaction with the Stokvis-Jaffe; moderate with Porter and Obermayer; faint with the Mitchell-Jaffe proportion.

Case 8. Twenty-four hours' urine of a diabetic of long standing with three per cent. sugar: all four tests negative. (This suggests inquiry as to his diet.)

Case 9. Twenty-four hours' urine of a young girl with chronic so-called parenchymatous nephritis, not eating meat at all: all four tests negative.

Case 10. Twenty-four hours' urine of a man plainly suffering from intensinal indigestion before and after administration of intestinal disinfectants: first analysis (before taking the sulphocarbolates, etc.), all four tests show more or less color, marked with three, moderate with the Mitchell-Jaffe; second analysis (after beginning treatment), moderate reaction with the Stokvis-Jaffe, negative, or faint with the others; third analysis, marked reaction with the Stokvis-Jaffe, moderate with Obermayer, slight with Porter, negative with the Mitchell-Jaffe; fourth analysis, all faint or negative except the Stokvis-Jaffe, which is only fairly marked.

From the above it will be seen that marked reaction occurred six times with the Stokvis-Jaffe test; three times with the Porter and the Obermayer each, and only once with the Mitchell-Jaffe. But it might happen that in the case of another sample of hydrochloric acid these figures would be different. Hence, it seems advisable to use a number of tests to meet the contingencies arising from variations either in the stages of oxidation of indoxyl or in the constitution of the chemicals.

It would appear from investigations so far pursued that if all four tests are positive there is no doubt about the excess of indican. If all tests are marked except either the Mitchell-Jaffe or the Stokvis-Joffe indican is excessive, and the acid used is the cause of the failure to obtain the color except in certain proportions.

If either the Mitchell-Jaffe only or the Stokvis-Jaffe only is marked, while the Porter and Obermayer are negative, the condition is likely to be lessening in severity on the one hand or not of paramount importance on the other.

If all four tests are negative, there is certainly no excess of indican, provided also no bright red tints are obtained, especially with the Mitchell-Jaffe proportions. [This statement lacks confirmation at my hands, since so far such a combination has not been found.]

Acetate of lead may be used in all the tests to rid the urine of interfering substances, but thus far I have used it only in connection with the Obermayer test, which, however, has not given as many marked reactions as the Jaffe tests without any preliminary treatment with the acetate.

It must not be forgotten that indoxyl sulphate is a normal constituent or urine, and that all these four tests will produce a small amount of blue which can be extracted by chloroform, but unless the blue color is immediately extracted in marked quantity the condition is not worth considering. It is advisable to try the tests on normal urine until the eye becomes familiar with the shades of color. According to von Noorden no attention at all should be paid to anything but intense blue shades.

The second question, what is the significance of indicanuria, may be in general answered as follows: Indicanuria is either due to the hearty eating of red meats, to intestinal indigestion, or to putrid pus absorption. When, therefore, from our tests as described above we conclude that an excessive percentage of indican is present, the diet of the person must be investigated, and, after removing red meats, the urine is to be tested again. If the urine of a diabetic supposedly on a diet rich in red meats shows absence of a marked reaction, inquiry should be made as to whether he is adhering to his diet, especially if at the same time sugar is present in quantity more than one per cent. in the 24 hours.

It is my experience thus far that a diet rich in the red meats does not lead to the production of intense reactions with all four tests. If further experience verifies this observation, then a point is gained in that a four-test indicanuria may be regarded as pathological. Supposing now that the red meats are eliminated from the dietary and still the marked indicanuria is observed, is the condition one of intestinal indigestion or of "pus somewhere?" In answer to this question it may be affirmed with tolerable certainty that if the administration of intestinal disinfectants makes the four tests irregular when previously all four have been positive, and if those now more or less positive are not so marked as they were before the remedies were taken, then the condition is one of intestinal indigestion, and, if the general condition of the patient improves to a marked degree, then the intestinal condition is the primary one, but if not, the intestinal condition is secondary.

If, however, the administration of intestinal disinfectants is not attended by a diminution of the intensity of the reactions,

provided a thorough trial of different therapeutic agents is made, the conclusion is that absorption of putrid pus is somewhere taking place. The remedial agents more commonly employed are the sulphorcarbolates, naphthol, bismuth, and certain special products of proprietary origin. While it is possible that these agents may not entirely remove the indican reaction a persistence of intense reactions with all four tests should be regarded with suspicion, when the patient is under intelligent treatment, and suggests thorough search for the locality where putrid pus absorption may be taking place.

The use of the four tests described above becomes of some importance with reference to surgical cases, and the writer suggests that hospital internes be required to make all four instead of one in cases where operation is contemplated. It is likely on account of the elusive character of the reaction that negative results have often been reported when positive ones could have been obtained by varying the proportions. Further study may show the advisability of varying the proportions. Further study may show the advisability of varying the proportions of urine and acid in cases where the Porter and Obermayer tests are apparently negative. In conclusion, let it be said that I have not attempted in this paper to prove anything beyond controversy, but merely to direct attention to the precautions necessary to betaken before reporting indican negative in a given sample of urine.—The Clinique.

SHOCK IN ITS RELATION TO ANESTHESIA

Emory Lanphear, M. D., St. Louis, Mo.

Much of that which we have been pleased to call "shock" in the past is now recognized as supersaturation with ether or chloroform in some cases, but more particularly poisoning from retained carbon dioxide in most—either alone or with too much anesthetic vapor. This is particularly demonstrated by the effects of hyoscine-morphine anesthesia (used hypodermatically) shock, except that due to profound loss of blood, has been practically eliminated from the work of those who use this method.

The terms "surgical syncope," surgical "shock" and "collapse" have been used rather vaguely and indefinitely by authors in the past. Recent investigations show that three different conditions are included under the term

Shock

(1) Circulatory shock, (2) respiratory shock, (3) nervous shock; to which may well be added (4) composite shock—a mixture of two or all three of the preceding.

1. Circulatory Shock. Syncope may be due to so great loss of blood as to render the brain profoundly anemic; in which case death may occur before the patient can be revived (as in great hemorrhage in trauma, or by serious, continued loss of blood during operative work). Or it may depend upon vaso-motor disturbances of such degree as to temporarily menace life, caused by the character of injurq or surgical procedure; belonging, therefore, to the group of "nervous shock," although the immediate symptoms are caused by cerebral anemia.

Circulatory shock, as seen upon the operating table, is about as follows: The patient has been doing well, apparently, in spite of perhaps enormous loss of blood; suddenly there is marked pallor of face and lips, a feeble or imperceptible pulse, cold and sometimes clammy extremities, dilatation of pupils, shallow respiration—general collapse. Here the trouble is not weakness of the cardiac muscle(hence strychnine in circulatory shock is worse than useless), but insufficiency of blood in the heart chambers there is not enough blood to permit the requisite to be sent to the brain. Unless something can be done to quickly restore cerebral circulation death from acute anemia of the brain will follow.

It is in this class of cases that greatest benefit is to be derived from hypodermoclysis, or in condition of great peril from intravenous injection of normal salt solution or even transfusion. As a matter of fact, injection of salt solution for shock is strictly indicated only in this class of cases; hypodermoclysis as well as hypodermatic injection of strychnine being greatly overdone—used injudiciously, if not harmfully—in every part of the world. Preceding hypodermoclysis the head of the table should be lowered and in extremely bad cases the legs bandaged in order to throw as much blood into the brain as possible; and after return of the patient to bed the foot of the bed must be kept elevated until good circulation is restored.

The same kind of syncope sometimes occurs by sudden change of posture, as when a patient in full anesthesia is raised to the sitting position for adjustment of dressings; but is then purely transitory. Of much more serious character is the "shock" which sometimes follows removal of a huge intra-abdominal growth (typically in tumors of the kidney, or other retroperitoneal tumors), which owes its origin to wide dilata-

tion of the splanchnic area, because we do not now possess any agent which can completely and quickly drive the blood from the huge vessels of the abdomen into the brain and skin. Here atropine and glonoin are the indicated drugs, and instant application of heat to the extremities is the next best thing. Lowering the head is also indicated—the exaggerated Trendelenberg position being advisable for some time, with only gradual restoration to the horizontal.

2. Respiratory Shock. The syncope of asphyxia, the supersaturation of the patient with an inhalant anesthetic, the "shock" which often comes on unexpectedly because there has been no great loss of blood, presents much the same symptoms as the circulatory variety, the cyanosis giving way to pallor with dilated pupils and shallow or absent respiration; but the pulse is generally good and in some cases even full and bounding. For here the right heart is embarrassed by distension and labors energetically, tumultuously, to force the blood into the lungs for oxygenation—this continuing until the heart muscle becomes poisoned with asphyxial blood. Most deaths, on the table, from chloroform occur in this way, although it is true, as said by Hewitt, that "there is good evidence that when certain anesthetics are administered in large doses the heart muscle may be suddenly paralyzed, but it is highly probable that when anesthetics are thus administrated other important factors capable of bringing about circulatory failure come into play."

Based upon the two statements just made, two rules should be formulated and well fixed in the mind of every anesthetist: (1) The administration of any anesthetic should be begun with extreme care, slowly, with close observation of its effect on pulse, but after anesthesia is well under way the pulse is of only minor import. (2) After the patient is anesthetized the respiration must be the chief guide to safety—any tendency to failure of respiratory effort and particularly any indication to cyanosis must be regarded as a signal of danger and immediately remedied. To wait until there is total abolition of respiration, necessitating cessation of operative procedures and resort to artificial respiration, is, in the vase majority of cases, pure carelessness on the part of the anesthetizer and not "idiosyncrasy" on the part of the patient.

Only too often asphyxia comes from dropping of the tongue into the pharynx or letting the palate close the air passage by permitting the jaw to drop back or down too far. The anesthetist who under such circumstances catches the tongue with forceps and pulls is forward ought to be kicked from the operating room—all that is necessary to do is to remove the

pillow from under the patient's head and to pull the jaw forward and upward by placing the thumb and forefinger behind the angle of the jaw and making traction forward and upward.

In this form of shock the first indication is to restore breathing by resorting to artificial respiration if the natural efforts have ceased. If they are merely shallow and irregular oxygen by inhalation is the surest remedy if at hand. If not—which is generally the case when wanted—galvanism is of use; but this, also, is frequently not ready when needed. So one must usually depend upon medicines. Here injection of a large dose of strychnine is permissible, though heart stimulation is not the special object to be attained but stimulation of the respiratory center—the heart will take care of itself if the blood can be oxygenated. Digitalin, as increasing the action of the left heart, would seemingly be indicated; but it must be recalled that the left heart it empty, the right surcharged with poison-ladened blood which can not be forced through the inactive lung. The inhalation of aromatic spirits of ammonia is sometimes good. In bad cases of respiratory failure forcible dilatation of the sphincter ani will start respiration. Hypodermic injection of sulphuric ether or of whisky sometimes stimulates the respiratory center into activity.

As soon as the "shock" has subsided (and it frequently disappears almost as suddenly as it comes on) the operation may be completed, under just as little anesthetic as possible, and the patient put in bed as soon as safety will permit; for these are the cases in which so-called "secondary shock" (not due to concealed hemorrhage) is likely to appear.

3. Nervous Shock. This form of shock is best illustrated by the man whose leg is run over by a locomotive; the loss of blood is not great, the mere severance of a limb should not ordinarily prove fatal, the pain though sudden and excruciating is not greater than often borne, yet the man dies of "shock"—the impress upon the central nervous system has been so great that "reaction" can not take place. Now this exact condition may arise, but fortunately in less degree, during an operation under anesthesia—the "stimulation of the cardio-inhibitory center by afferent impulses through the vagus" being the usual explanation. But, whatever the mode of conduction, by reason of tremendous disturbance of the vaso-motor system this form of shock is greatly to be feared; and there can be no doubt that the pernicious influence of the anesthetic itself, in too large quantity, upon the nerve centers has much to do with its production. The lesson of the anesthetist is, therefore, to learn how to carry the patient up to the

critical period of operation with the smallest possible quantity of anesthetic, whatever it may be, yet have the anesthesia so complete at the proper point that a severance of the great nerve trunks shall not be felt, or that ligation of any huge vessel (like the femoral or subclavian) shall not be attended by any disturbance sufficient to jeopardize life. This is difficult to do and is one of the things which makes the experienced surgeon often say that the responsibility of the anesthetist is frequently greater than that of operator.

In the treatment of this form of shock strychnine finds its proper use: 4 milligrams (1-15th of a grain) may be injected as soon as the shock is apparent. Glonoin, too, is often of advantage in dose of one milligram (gr. 1-67th). Hypodermoclysis is of doubtful utility, though commonly used. This form of shock is almost unknown when the hyoscine-morphine-cactin anesthesia is used—one of the great advantages of this combination.

4. Secondary shock is often merely the effects of too much anesthetic, plus more or less carbon-dioxide poisoning from replacement of pure air by excess of the vapor of ether or chloroform for a long time. It is particularly apt to occur when large quantities of ether have been given by a man who believes in "crowding it on" until the patient is cyanotic.

This asphyxiation or carbon-dioxide poisoning, added, to the direct effect upon excretions and metabolism of the anesthetic itself, constitutes the fourth or "composite" variety of "shock" during and after anesthesia.

Its treatment is essentially that of the effects of asphyxia: plenty of fresh air, elimination by the skin (induced by hypodermoclysis if necessary, or by subcutaneous use of pilocarpine); washing out the stomach, in which large quantities of ether (and in less degree chloroform) may be found; free catharsis by giving a large dose of Epsom salt in the stomach at the conclusion of lavage, or by hypodermic injection of salicylate of physostigmine, 1 milligram (1-60th grain) every hour four times, and by use of high enemas containing ox gall and turpentine, and especially by the external application of heat.—(Texas Medical Journal.)

LOS ANGELES ECLECTIC MEDICAL SOCIETY

The regular monthly meeting of the Los Angeles Eclectic Medical Society was held Monday evening, February 3, 1919. The application of Dr. Hugo Foss for active membership was presented and accepted by the society. Following the usual course of business two papers were read. The first, entitled

"Pneumonia," was contributed by Dr. Aisbitt. The second, entitled "Influenza," was read by Dr. H. Ford Scudder. Both papers will appear in this Journal. The subjects were well discussed bringing out many interesting points along the line of the etiology and treatment of these conditions. It was suggested that a committee be appointed to collect a record of the cases of influenza treated by Eclectic physicians with the death rate of same as compared with other systems of medicine, with particular reference to Allopathy and that such report be given proper publicity. The treatment of hiccoughs was discussed. Tela Aranea is suggested by Dr. A. P. Baird as an efficacious remedy for this condition. The stoppage of hemorrhage by the local application of a weak solution of methylene blue was suggested by Dr. Clinton Roath. This valuable piece of information was acquired by the doctor while attending clinics in the East.

The next meeting of the Society will be held on Monday, March 3, 1919, at the residence of Dr. J. A. Munk, 747 South Alvarado Street, Los Angeles.

CATHERINE E. OHNEMULLER, M. D., Sec'y.

SOCIETY CALENDAR

National Eclectic Medical Association meets in Detroit, Michigan, June 18-19, 1918. Dr. W. P. Best, Indianapolis, Ind., President; Dr. H. H. Helbing, St. Louis, Mo., Secretary.

Eclectic Medical Society of the State of California meets in Los Angeles, May, 1918. H. V. Brown, M. D., Los Angeles, Cal., President; A. P. Baird, M. D., Los Angeles, Secretary.

Southern California Eclectic Medical Association meets in May, 1918. Dr. Clinton Roath, Los Angeles, President; Dr. H. C. Smith, Glendale, Secretary.

Los Angeles Eclectic Medical Society meets at 8 p. m. on the first Monday of each month. F. J. West, M. D., Los Angeles, Cal., President; C. Ohnemüller, M. D., Los Angeles, Secretary.

NEWS ITEMS

H. T. Cooke, M. D., has opened an office at 410 Ferguson Bldg., Los Angeles, and will specialize in anesthesia.

Dr. J. R. Buckingham, having been released from the army after a year in the service, has located at 2102 West Seventh street, Los Angeles.

Dr. W. F. Holman has returned and opened an office at 800 L. A. Investment Bldg., Los Angeles.

Born: To Dr. and Mrs. Elmer L. Smythe, a daughter, Annette Elizabeth, at Haverhill, Massachusetts, on January 23, 1919. Dr. Smythe is located at Bremerton, Washington, but at present is a lieutenant in the Medical Corps at Camp Kearny, California. The Journal extends congratulations.

Dr. A. C. Pritchard, after serving seventeen months as Captain in the U. S. Medical Corps, has returned to Hot Springs, Arkansas, where he is located in the Thompson Bldg.

Dr. J. C. Stout has changed his address from 1152 East Fourteenth Street, to 128 Thirteenth Street, Oakland, Calif.

Dr. John W. Cosford, N. 1716 Monroe Street, Spokane, Washington, wishes to retire from practice and desires to sell his office and residence to a hustling young Eclectic. This would be a splendid location as Dr. Cosford is the only Eclecic there.

Captain W. E. Smith has been released from service in U. S. Medical Corps and has returned to his practice in Whittier, Cal.

Dr. and Mrs. H. V. Crook, Big Pine, visited in Long Beach and Los Angeels for a few days last month. Dr. Crook has been appointed District Surgeon for the railroad.

Married—Dr. C. O. Hansen, Pasadena, and Mrs. June McNee, a member of the Long Beach Board of Education and a prominent club woman were married recently. Dr. Hansen has recently returned from the Army Medical Service. The couple will reside in Pasadena.

Died: Alfred N. Couture, Auburn, California, graduate of Hahnemann Medical College of the Pacific, San Francisco, 1894, California Eclectic Medical College, 1896, died at the White Hospital, Sacramento, on December 26, 1918, from cholelithiasis for the relief of which an operation had been performed.

Died: Mary Viola Cosford, Spokane, Washington, graduate of the Eclectic Medical College, 1885, died at her home on October 28, 1918, after an illness of sixteen weeks from pyelitis. She was a member of the Michigan and National Eclectic Medical Societies and practiced for twenty-five years at Mancelona, Michigan, retiring in 1905 and moving to Spokane, Washington. She was 63 years old, and leaves a husband, Dr. John W. Cosford.

DIED—George W. Finch, died at his home in Los Angeles, on February 23, 1919. He was a graduate of the California Eclectic Medical College, 1890, and had practiced in Los Angeles many years. He is survived by one son.

HANDS AND POCKETS

Corporal Ellsworth O. Terrill had his hand in his pocket when he went over the top in the vicinity of Hagenbach, Alsace, France, August 21, 1918. He did it to hide something, but was discovered in the act of deceiving his sergeant and for the offense was cited in orders and given the distinguished service cross by General Pershing.

In the coming Victory Liberty Loan there will be many who will be giulty of deception. Many hands will be put in pockets and withdrawn empty. Other millions will go deep in their pockets to bring out savings and then pledge future earnings to make the heroism of Corporal Terrill worth while.

When the time comes for us to put our hands in our pockets to answer the call of our government that was bulwark for our homes we should forget our excuses and remember the hand that Corporal Terrill stuck in his pocket. It was mangled and torn; the ribbons of red were centered with jagged pieces of white blasted by the Hun. Because the remnant was less than useless and if discovered would cause him to lose his part in the counter attack he stuffed it into his pocket, pursued the enemy and threw hand grenades at the retreating enemy with his left hand.

Suppose we think of Corporal Terrill when we put our hands in our pockets for the Victory Liberty Loan.

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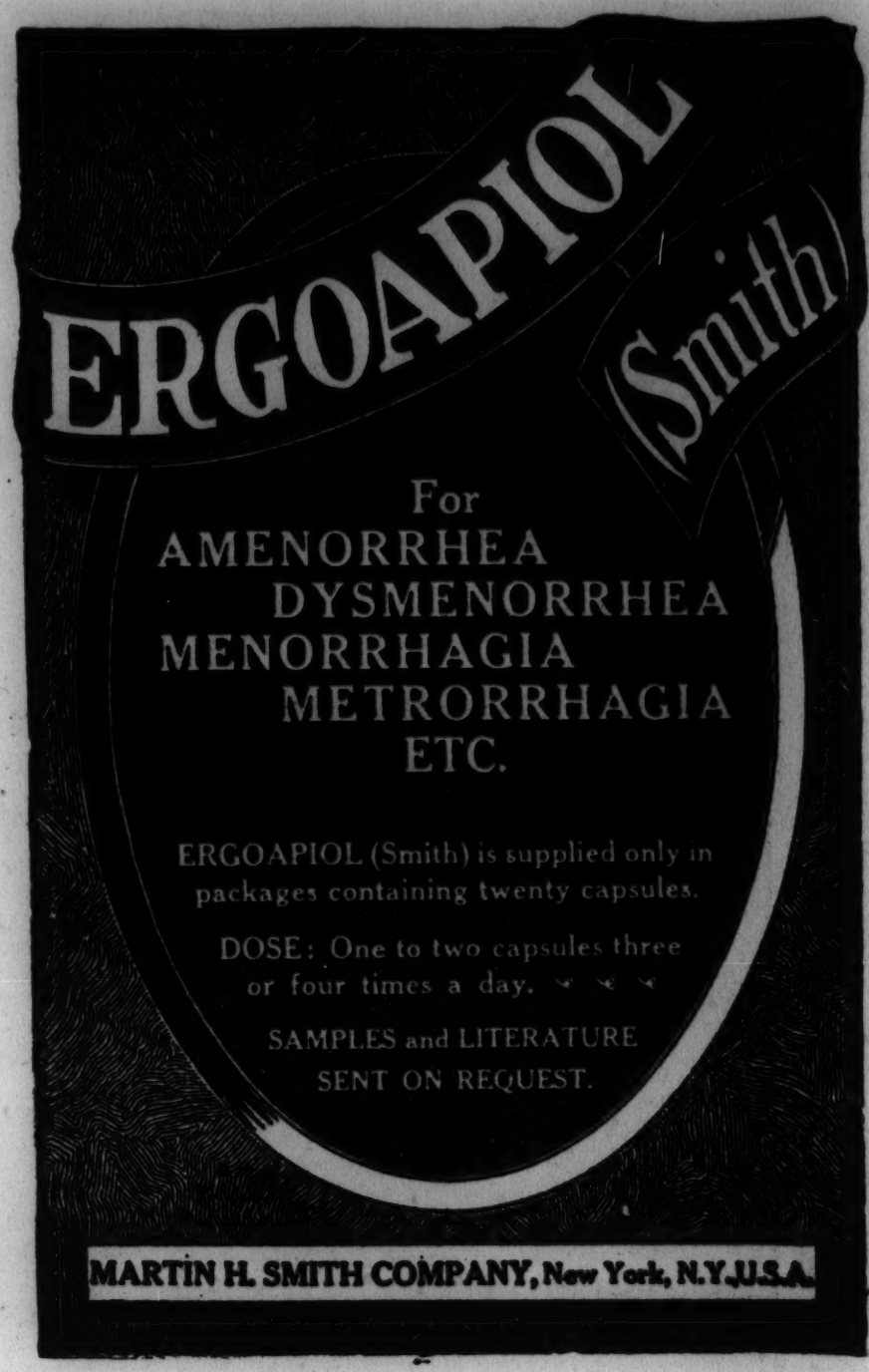
	Price.	Club Rate.
California Eclectic Medical Journal, 819 Security Bldg., Los Angeles	1.00	.90
Eclectic Medical Journal, 630 W. 6th St., Cincinnati, Ohio	2.00	1.80
Ellingwood's Therapeutist, 32 N. State St., Chicago, Ill	1.50	1.35
National E. M. A. Quarterly, 630 W. 6th St., Cincinnati, Ohio	1.00	.90

You may subscribe to any or all of the above journals through this office, the only condition being that subscriptions are paid in advance and 10 per cent discount allowed on an order for two or more, including this Journal.



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